Department of Health and Human Services, Centers for Medicare & Medicaid Services

All Tribes' Call: CY 2018 Medicare Diabetes Prevention Program Model Expansion Final Rule

Wednesday, November 29, 2017 • 2:00 – 3:00 p.m. Eastern Time

Phyllis: Good afternoon. My name is Phyllis and I will be your conference operator today. At this time, I would like to welcome everyone to today's all tribe call on Medicare Diabetes Prevention Program. All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session.

If you would like to ask a question at that time, please press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you. I would know like to turn the call over to Kitty Marx, Director, Division of Tribal Affairs CMS. Please go ahead.

Kitty Marx: Hey, thank you, Phyllis. Good afternoon and welcome to today's CMS all tribes call on the calendar year 2018 Medicare Diabetes Prevention Program model expansion final rule. That's a handful. I'm Kitty Marx, Director of the Division of Tribal Affairs. Joining me on today's call is Dr. Susan Karol with the Division of Tribal Affairs and also Carly Bird and Chinara Smith from the CMS Innovation Center.

The purpose of today's all tribes call is to provide an overview of the Medicare Diabetes Prevention Program final rule and to provide an opportunity to answer any questions you might have. As part of the save the date notice that you received, there was a link to a Medicare Diabetes Prevention Program fact sheet and also to all those who registered, you should have received a copy of the fact sheet. We'll be walking through that fact sheet today.

On November 2nd, 2017, CMS issued the calendar year physician fee schedule which finalizes the policies to implement the Medicare Diabetes Prevention Program expanded model. This model allows Medicare beneficiaries to access evidence-based diabetes prevention services with the goal of a lower rate of progression to Type II diabetes, improved health, and reduced spending. At this time I'd like to turn the call over to Carly Bird from the Innovation Center who will provide an overview. Carly?

Carly Bird: Great. Thank you, Kitty, and thank you everyone so much for joining today. I'm really happy to be here to be sharing a briefing of our final rule which was published in the Federal Register a few weeks ago now on November 2nd. This is the second of two rules that have been published on the Medicare Diabetes Prevention Program.

The first rule was published in last year's physician fee schedule. This rule really established the framework for the Medicare Diabetes Prevention Program including general services policies, leading out the new supplier class that would

be furnishing MDPP and providing some overviews of the proposed payment structure, but left a lot of policies to this year's physician fee schedule.

This year's final rule finalizes the additional policies that were necessary to implement the services starting in 2018. More specifically, this rule finalizes that suppliers will be able to begin enrolling in Medicare in 2018. It finalizes the payment policy. The rule also goes through and finalizes several supplier enrollment requirements and compliance standards that are in that, enhancing program integrity for the program and also make some amendments to beneficiary eligibility and the services policies.

I'm going to go through the fact sheet that was attached to the calendar invite and can also be found on our website. If you do not have that, you can go to go.cms.gov/mdpp. Scroll down and you'll be able to find our fact sheet as well as a bunch of other information on our website. I will walk through this fact sheet briefly and provide a high level overview of all of the major policies that were finalized in this rule and then we will take your questions once I'm done.

The first major policy that we finalized in this rule is around the effective date of MDPP services. Last year, we did finalize that we would be going live with the expanded model on January 1st. In this year's rule, we had proposed to delay that to April to allow enough time for suppliers to begin enrolling in January. We did finalize that change and the policy that we finalized allows suppliers to begin enrolling in January, January 2nd to be exact, and the model will go live April 1st.

April 1st is the first day that suppliers will be able to furnish services to Medicare beneficiaries and the first date where suppliers will actually be able to receive payment for furnishing those services. The months leading up to April 1st will be time for the new supplier class to enroll in Medicare, which is usually a 45 to 60 day process but can take longer depending on how the application goes and if everything is correct on that application.

The next major set of policies that we finalized in this rule relate to how the MDPP services are furnished, beneficiary eligibility, and payment policies. How I'll do this is I will briefly touch on, give you some context of what we finalized last year so it can orient you in how this fits into the broader picture of MDPP. The first major policy is around beneficiary eligibility diabetes diagnosis during MDPP services period.

Last year, we finalized the majority of our beneficiary eligibility policies. These final policies require suppliers to check beneficiaries' eligibility in terms of their pre-diabetes status before they enter the program. Specifically, beneficiaries are not able to enter the program if they have a previous diagnosis of Type I or Type II diabetes. We do allow individuals who have a previous diagnosis of gestational diabetes to enter the program. That was included in last year's rule.

What we proposed this year and what we finalized is that if an individual is receiving MDPP services but develops diabetes during the program, they can continue to receive MDPP services. They won't be kicked out, they won't lose their eligibility. Suppliers can continue to offer MDPP services to individuals if they develop diabetes during the services period.

Another policy that we finalized is around the core services and ongoing services period. Last year, we finalized the structure of the services that there would be one year of core services. That was broken up into a six month period of more intensive core sessions followed by a six month period of what are called core maintenance sessions. These are monthly maintenance sessions that reinforce the learnings of the first six months.

Last year, we left it open-ended as to how long we would require ongoing maintenance sessions after the first year. In this final rule, we finalized a limit to the ongoing maintenance sessions of one year. What that does is it creates a two year maximum services period. The first year, all beneficiaries who are eligible for MDPP have access to that entire year. In the second year, only those beneficiaries who have met the weight and attendance milestones can continue to receive ongoing maintenance sessions.

We did make some tweaks to the eligibility around ongoing maintenance sessions. I'll talk more about this too when I go over the payment structure and the finalized payment policy. As it relates to beneficiary eligibility and ongoing maintenance sessions so that you're following the first year, beneficiaries have to attend at least two out of three monthly sessions in order to be eligible for the next ongoing maintenance session interval. Those intervals are three month intervals.

A beneficiary attending at least two of the three month interval sessions will be able to continue to receive services over the 12 month period. For the payment structure, we finalized a performance-based payment structure. What this does is it ties payment to performance goals based on attendance and weight loss. This is a similar structure that was both included in last year's rule and proposed in this year's rule.

There were some modifications made to the actual payment amount in this final rule as compared to what was proposed in the PFS earlier this summer. The structure itself remains the same with the exception of the removal of the third year of ongoing maintenance sessions, which is what we had originally proposed. There's one year of core services. If you go down if you're looking at the fact sheet, I will just briefly go over the payment amounts and how we're structuring them.

For the first year of the core services period, there is a $25 payment for beneficiaries who attend the first session. That payment goes up to $50 for attendance of the fourth session and up to $90 for attendance of nine core sessions. Those are those sessions in the first six months of the program. After

the first six months of the program when a beneficiary switches to core maintenance sessions, that's when the payment changes into a more performance-based payment structure.

The first six months really payments are based on attendance only. In the second six months, the payments are more based on whether the beneficiary achieves that minimum weight loss. In the second six months, there is a $60 payment available to suppliers for each three month interval that is furnished to beneficiaries if the beneficiary maintains that 5% weight loss and attends at least two of the three monthly sessions within an interval.

Again, this is a change from what we had originally proposed. We had proposed that the beneficiary would have to attend all three of the monthly sessions in order for the supplier to be eligible for that payment. We, based on public comments that we received, we determined that it would be best to allow some flexibility for beneficiaries and for suppliers receiving payment. We reduced that requirement to only requiring two of the three monthly sessions.

A $60 payment is available for both weight loss and attendance of at least two out of the three. There is a $15 payment for attendance only. If a beneficiary moves from the core sessions in the first six months to the core maintenance sessions in the second six months but only meets that attendance milestone, at least two out of three of those monthly sessions, then the supplier is eligible to receive a $15 payment for that beneficiary for those sessions furnished.

Following the first year and actually, I should go back. Within the first year, there are two weight loss-based incentive payments. There is a $160 payment available to suppliers if a beneficiary achieves that minimum 5% weight loss and an additional $25 bonus payment if the beneficiary achieves 9% weight loss. Those did not change from what was originally proposed.

For ongoing maintenance sessions, and remember, it's one year of ongoing maintenance sessions not available to all beneficiaries but only available to those beneficiaries who have achieved that 5% weight loss during the core, the first year of the core services period. In those ongoing maintenance sessions, suppliers are eligible to receive $50 if the beneficiary achieves the attendance and weight loss milestones.

That would be both maintaining that at least 5% weight loss during, at least once during the three month session and attending at least two out of the three monthly sessions. All in all, this equates to a $670 total maximum payment for beneficiaries who meet all of the performance goals and a $195 payment for beneficiaries who meet all the attendance-based milestones. This payment definitely represents a shift in payment towards attendance and a bit away from weight loss.

What we had originally proposed was more heavily weighted towards those core maintenance sessions. We shifted some of the monies that we eliminated in the third year into that first year of core sessions and core maintenance sessions. We also in our rule, we included the corresponding, they're called HCPC G-codes. They're the codes that suppliers submit to CMS in order to receive payment.

There is a code associated with each of these payments that I just went through that are in the table as well as additional codes. I really encourage you if you are a supplier or a prospective supplier or involved with an organization that is planning to be a supplier, definitely check out that part of the rule that talks about the claim coding systems that we will be using. There are specific G-codes that will be included on claims that are sent to CMS.

In last year's rule, we talked about beneficiaries switching providers. We stated that beneficiaries would be able to switch between suppliers, but we didn't say anything about how that might impact supplier payment. In this year's rule, we actually finalized a new payment called the bridge payment. This is in the case where a beneficiary switches midway through the program to a new supplier.

That new supplier, because they're taking on a beneficiary who might be in the middle of, let's say, a core maintenance interval or could be in the middle between the fourth and the ninth session, the new supplier is taking on some level of financial risk for that new beneficiary. We have included a $25 payment for the first session furnished to any newly accepted beneficiaries who are switching midway through the program to a new supplier.

The next set of policies that we finalized in this rule were regarding supplier enrollment and compliance standards. In last year's rule, we finalized that the organizations enrolling in Medicare in order to furnish this service would be MDPP suppliers. We established that supplier class and we also established that the supplier class would be based on CDC recognition as an eligibility criteria prior to enrollment.

In this rule, we added an eligibility criteria for the suppliers called MDPP preliminary recognition. This preliminary recognition will allow suppliers who haven't yet met that full recognition to enroll in Medicare as MDPP suppliers and furnish MDPP services and receive payments. The preliminary recognition standard is based on attendance and not based on weight loss.

CDC actually is the governing body of the recognition standards and included the preliminary recognition there in their what are called the DPRP standards, the Diabetes Prevention Recognition Program standards. Those were published the same time as the proposed rule and are still expected to go into effect in January. However, there might be a lag time between when our rule goes into effect on January 2nd of this next year and when those standards go into effect.

We finalized what's called MDPP preliminary recognition, which will allow organizations that have met that attendance-based standard to enroll in Medicare while before the DPRP standards are released. Any organization that is enrolling under interim preliminary recognition would transition to CDC's preliminary standard once that becomes effective and won't experience any disruption in their enrollment with Medicare.

We've been coordinating very closely with CDC to facilitate this process, but I'm happy to answer any questions about that as well. We finalized a number of supplier standards to protect against fraud, waste, and abuse in the MDPP program. These standards are really designed to make sure that MDPP suppliers are operational to protect beneficiaries against getting denied access to services and put in place several other program integrity safeguards.

There are also standards that for coaches that will be included on the enrollment application an organization will submit to CMS. There are, for example, a coach cannot have been terminated from Medicaid for a cause or they cannot have received certain felonies within the last decade. These types of information will be screened as part of our enrollment process.

That's why we have finalized that in our last rule that the suppliers would submit to CMS a roster of their coaches which includes [NPIs 00:19:33] of each of their coaches. Happy to answer more questions about that as well, but there are several other standards that I didn't mention in here that are discussed in greater detail in the rule.

We finalized that suppliers that are re-enrolling or re-validating their enrollment which is something all providers in Medicare have to do on a regular basis would do so at a moderate categorical risk level. Last year, if you're familiar with the rules from last year, we did finalize and haven't changed that the newly enrolling organizations would enroll at a high risk screening.

Upon re-enrollment, which will happen every five years, the organizations would enroll at a moderate risk level. That risk level will require fewer requirements of the organizations than the high risk level. Finally we, actually the second to last thing on this fact sheet is around beneficiary engagement incentives. This is a new proposal. We didn't discuss this last year, but we did receive a lot of stakeholder input that led to the development of this policy.

We finalized that in a supplier can choose to provide certain engagement incentives to beneficiaries to help the supplier with any kind of behavior change that they're working with the beneficiary on. Whether that is trying to meet an attendance goal or trying to meet a weight loss goal, an incentive can be furnished. There are conditions upon which these incentives can be given. For example, they have to be a preventive care service item or help advance one of the clinical goals of the program.

I definitely encourage you if, again if you are a supplier or an organization thinking about becoming a supplier, rather, that you consult your counsel or outside counsel on furnishing any kinds of additional incentives that you might have as part of other programs to make sure that whatever you plan to give beneficiaries meets the conditions that we have laid out in our regulations.

Finally, we finalized makeup sessions policies and this policy would allow suppliers to offer makeup sessions which is aligned with what CDC allows as part of their standards. We do allow a limited number of virtual makeup sessions. These can be offered to beneficiaries who miss a regularly scheduled session. There is a limit to the number of virtual makeup sessions. It is four per year and three in the second year.

These again can only be offered if someone missed a session. They can't be offered to an entire class of beneficiaries as part of the program. Those are the major policies that we finalized in this rule. I am happy to take questions. I will note first a couple things for you if you want more information. We do have a mailbox now setup that we are trying to respond to within a few business days questions that we receive from external stakeholders. That mailbox is mdpp@cms.hhs.gov.

There you'll find a registration link to our [MLM 00:23:17] webinar, which is a webinar on Tuesday next week, so December 5th, where we will be going through all of the final policies in great detail. It's about ... I think it's an hour and a half long. We will be walking through the final rule and also touching on last year's final rule so that we can put the whole package together for everyone in one presentation.

I definitely encourage you to sign up to attend that next Tuesday. It will be recorded, so you'll be able to watch it again if you can't make the webinar next Tuesday. One final thing I did forget to mention, this is a question that Kitty had sent to me related specifically to the Indian health services. I apologize because this, it doesn't seem like this made it into the rules specifically.

This is around the regulation at 45 CFR 80.3(d) which allows Indian health services ... From what I understand, it allows Indian Health Service providers to only accept beneficiaries who are part of the Indian Health Service. What I'll say about this and we will also plan to include this in an FAQ or some kind of resource as part of future guidance that we've put out. Generally, MDPP suppliers are required to abide by all regulations governing Medicare providers and suppliers in Subpart B of Medicare regulations and also any other applicable regulations.

This would be including but not limited to the regulation around IHS access to IHS providers. MDPP services are not changing anything about that current policy. The IHS providers should just assume that everything remains the same for MDPP services in terms of how that policy is currently administered. With

that, I will pause and open the line up or send it back to Phyllis the operator to open up for questions.

Phyllis: At this time, if you would like to ask a question, please press star then the number one on your telephone keypad. That was star then the number one. We'll pause for just a moment to compile the Q&A roster ... Your first question comes from the line of Denise McKeon with Washoe tribe.

Denise McKeon: Yes, hi. Could you please repeat the mailbox address?

Carly Bird: Sure, no problem. It's MDPP, as in Medicare Diabetes Prevention Program, that's the acronym, mdpp@cms.hhs.gov.

Denise McKeon: Okay, perfect. Thank you.

Carly Bird: No problem.

Phyllis: Again, if you would like to ask a question, please press star then the number one on your telephone keypad ... Your next question comes from the line of Cassandra [Sellert 00:26:56] with [inaudible 00:26:58] tribe.

Cassie: Hi, this is Cassie. Can you hear me?

Carly Bird: Yep, I can. Hi, Cassandra.

Cassie: It's not the [inaudible 00:27:08] tribe, it's the [inaudible 00:27:10] tribe. Anyhoo, so I was wanting to know, it wasn't exactly clear to me how CMS addressed the issues that the tribes brought up and what their final decision ... I don't like the rule-making. I've expressed that to many a director, however, the decision regarding the issues the tribes have specifically brought up in the Portland area Indian Health Board letter that they sent and then also with the affirmation of the Tribal Leaders Diabetes Committee with concerns about weight requirements and those kind of issues.

Carly Bird: Sure. Are you talking specifically about using weight loss to drive payment?

Cassie: Exactly.

Carly Bird: Sure. Unfortunately, this isn't something that we were able to change at this time. We actually proposed that the 5% weight loss would be the metric of performance in last year's rule. That would be what we would use to determine eligibility for beneficiaries for the ongoing maintenance sessions. That was finalized last year. We didn't reopen it for a new proposal.

This year what we did do which, and I'm pulling up your comment right now because I'm not remembering the specifics of what was said here. I assume that it was around the payment. We did receive a fair number of comments around

using different levels of payment. I'm sorry, different levels of weight loss or different metrics of weight loss in order to drive payment. This is just not something that we at this time have the ability to change.

This is something that we felt was necessary in order to reflect what the original evaluation of the program showed. That was that weight loss is the key driver of reduction in diabetes and we don't have other metrics to tie that to. The way that our process works with expanded models is we have to have a research base that demonstrates effectiveness that meets statutory criteria for the model to be expanded. That's what happened here. Our office's actuary use that 5% weight loss to predict savings that Medicare would accrue over time based on this service.

If it weren't for that 5% weight loss metric being tied to payment, we would not have received certification to move forward on MDPP services at all. The 5% weight loss at this time is what we have to work with for our payment policy. Now that's not to say that there could be something in the future that could change. This is the first of its kind, the first preventive service in fact that has been offered in this way through a lifestyle intervention.

I think as we implement the program and monitor and study how it works and how it works across different populations, then weight loss metric and how effective that is in actually showcasing the program's effectiveness is something that we're [inaudible 00:30:57]. It wasn't something that we were able to change within the parameters of the current program at this time. We had to base our policies on what was evaluated in the model test originally and what was certified by our actuaries to expand.

Cassie: Okay. I would like to go onto the record for saying that we as the tribes in the Pacific Northwest have given comment about how that's not acceptable. We of the Tribal Leaders Diabetes Committee have also said that is not acceptable. There are other things that you can do. The piece that it seems that everyone is missing and not taking into account for is generational trauma.

The risks of poverty and the risks of homelessness and all the other things that afflict Native Americans continues to not be the recognition of CMS of the tribal programs and how we have statistical data how we've had them be successful. That is a concern. The lack of looking at our programs when in fact you can change it and you can listen to the tribes. You can take the tribes' comments. You're still continuing to choose not to.

That's very disturbing to the tribes. Very disturbing that you think that weight does play an important role, but you're using non-reservation, non-Indian people's data to try to affect Native American which has completely different resources and completely different situations. You're not being culturally sensitive that way. I'm going to continue to remind you that every single time because you're not listening to the tribes. That's my comment.

Carly Bird: Thank you. I appreciate that. We actually, and you're not ... I think the tribes are one of many minority groups that voiced similar concerns, which we do take seriously. We solicited comments on that particular piece as well. I appreciate you continuing to voice the concerns and also, Cassandra, if you do have any research or data or information along the lines of the points that you're making, I think it's always a good thing to share with us so that we can keep track of how different populations may be faring differently in our program as we roll out the program.

Cassie: We do have data. We've been tracking data since the inception of our programs. It's really frustrating to have CMS officials come to an all tribes diabetes conference and speak about CMS's diabetes program. They don't even have a clue as to what we've been doing the last 20 years in Indian country and how we've almost reduced and have proven practice and best practice for when it comes to reducing kidney failure and reducing dialysis in our communities.

We had a community that was one of the highest users per ethno population and we have almost eliminated that. I think CMS is not educated and not culturally sensitive to the Indian community to educate themselves about what's going on in Indian country. When I stood at the mic with your CMS representative and talked to him about the things that we were doing in Indian country, you had local CMS representatives come to me and say, "I don't know what program you're talking about."

How can tribes be doing diabetes care for 20 years and you still not know? It's on you as CMS to get educated and to be culturally sensitive and to invest in learning what beautiful things the tribes are doing to reduce diabetes and to reduce the problems that we have in our communities. Our communities are different. That is something that you have to open your eyes to be culturally sensitive to.

You're asking ... a lot of times, it's a resourcing. You're not giving money to change poverty or homelessness or those other things that are very specific. I'm not trying to kill the messenger, I'm just saying that we're going to continue to say the same thing until somehow you can listen and change. When all the tribes get together and send you a letter, it has to tell you it's important.

Carly Bird: Cassandra, what I'll say is I hear about the messenger aspect that you just noted. I would definitely encourage you to work with Kitty to see if there's other points of contact beyond the program team that might want to listen to what you have to say. I think that in the rule-making process, we are ... there's a process.

The staff here on my team have to follow that process. We only have control over so much. I wish I could tell you differently, that I have the power to change this, but it's not something that's within my personal wheelhouse. I've certainly voiced this to my leadership and they're aware of it, but I can only do so much there.

I will say though on the bright side, and this might not be a consolation, but we did listen to stakeholders when we decided to make the change to our payment policy to shift more to the attendance in the first six months. That was something that stakeholders across the board were asking for. We were able to move the needle there as much as we could under the current environment.

Cassie: What about the data requirement of a year's worth of data to even be able to apply for the program?

Carly Bird: That's actually something that we finalized last year.

Cassie: Mm-hmm (affirmative). That's unacceptable, also. You're asking tribes to run a program, not get reimbursed for a year, and then after a year of their own personal cost, running it not culturally sensitive, not in a way that they believe that they should. Elders who have diabetes who are underweight would have to lose weight, then be able to try to apply for a payment. That is unacceptable.

Carly Bird: That's definitely something that we've heard from other stakeholders as well. We definitely recognize it's a chicken or an egg situation. I think from the CMS perspective and what we put in our rules, we have to have some kind of demonstrated capacity for organizations, especially those that are new to Medicare enrollment, before we can enroll them. CDC recognition is what we based our model test on and we have to rely on that and some quality standard before enrolling a provider in Medicare to furnish services.

Cassie: Again, the tribes have been running diabetes programs for 20 years not CDC-based. We got to with IHS be self-determined, be sovereign, and make a diabetes program that's successful in our way. CDC is not a culturally sensitive diabetes program, meaning it doesn't meet the needs of Indian people. Our own tribes have created diabetes programs. Again, you're using a federal government standard based on a population that isn't Native American trying to use non-Native ways for diabetes that is not even applicable in our communities. They're not based off of our people.

Kitty Marx: Hey, this is Kitty Marx. Let me jump in here for just a second because I think we might have other people waiting in line.

Cassie: Okay. I'm sorry.

Kitty Marx: I just want to provide an update to everybody on the call and you, Cassandra, as well is that the CMS tribal technical advisory group met in November. We talked with a Medicaid subject matter expert about Medicaid state programs that have developed a diabetes prevention program at the Medicaid level. That's in Minnesota and Montana.

Minnesota follows the CDC requirements that's very close to the Medicare, but the Montana one is a lot more flexible. I think that this going through Medicaid

might be a way to address the Tribal Leaders Diabetes Committee's concerns for more flexibility, perhaps recognition of the special diabetes program at the local state level. Medicaid agencies have a lot more flexibility than Medicare at the national level.

We think that this might be an avenue to pursue. We would be, my staff along with the Medicaid experts would be willing to attend a Tribal Leaders Diabetes Committee to provide an update on the Medicaid diabetes prevention service programs and see how we could develop a model that other states could use as well in collaboration with the Indian Health Service and tribal facilities.

Cassie: I think it's amazing to think outside of the box and that's really important, but again, it's really important that we be able to as Native Americans carry our sovereign rights. We talked to the new IHS director for, potential IHS director about this issue and we talked to the current IHS director about this issue. It's really important and it's an opportunity for the federal government, CMS, and CDC to work together to recognize that the tribes do actually know what they know.

They're doing a great job, we have the statistics to prove it, [Anne Bullock 00:42:14] has the report. She's a federal officer, Dr. Bullock, and she knows these things. This, we have to continue to push this issue because it's not acceptable. The federal government can think outside of the box and it doesn't mean that we have to conform to a way that isn't our way. We have what's working in our communities. That has to be recognized because we have the statistical data to prove it.

Kitty Marx: Okay. Thank you, Cassandra. We appreciate [crosstalk 00:42:51]-

Cassie: Thank you. Yep.

Kitty Marx: Let's follow up on your concerns, okay? Phyllis, can we see if there's any more participants who have a question or comment?

Phyllis: You have a question from the line of Dolores Addison with Tohono O'odham.

Dolores Addison: Hi, there. Can you hear me?

Carly Bird: Yes.

Dolores Addison: Hi. I actually have two questions, if that's okay.

Carly Bird: Sure.

Dolores Addison: The first one, and I'm guilty of not doing as much of my homework as I should have when it comes to reviewing some information regarding MDPP. My first question is who's expected to teach the classes? Are we expected to have

health professionals like dieticians and nurse practitioners and nurses teach the courses or are health paraprofessionals like community health representatives and that sort of heath paraprofessional able to teach the classes and still receive payment?

Carly Bird: Sure. That's a really good question. It wasn't directly addressed in this rule, so it's probably, if you did read this rule, we didn't talk about this. It was more in last year's rule. We don't require any credentials for the coaches. The coaches within a MDPP organization will be the ones that teach the classes.

As long as those organizations and coaches follow the CDC standards for teaching the curriculum, they don't have to undergo any kind of specialized training. Although from what I understand, there are organizations that put their coaches through trainings or have them get certificates to become a health coach. None of that is required by CMS. What we require is that the coaches follow the DPRP standards.

Dolores Addison: Okay, great. Thank you. My other question, it kind of follows a little bit with what Cassandra was talking about with regard to attendance of classes. One of the things that has really worked in tribal communities is to allow families support systems to be a part of classes like diabetes prevention or diabetes health management classes whether or not the person has diabetes or meets the criteria for that certain class.

If, for example, a program here on [inaudible 00:45:29] Nation decides that they're going to open up their classes to everybody in order to provide support to the person who has, who's going specifically for the classes or just for increased knowledge or whatever, will these programs be penalized for that? Is it just basically they won't be given payment for the people who are there as support or who don't meet all the criteria?

Carly Bird: That's a really good question, too. It's making me think a little bit. What I'll say is ... and think about how I want to respond, not think about the actual answer. The answer is pretty simple. CMS Medicare will pay for beneficiaries who are Medicare beneficiaries only. We don't regulate how the supplier furnishes services to other people that are not Medicare beneficiaries, if that makes sense.

Dolores Addison: Mm-hmm (affirmative).

Carly Bird: I'll just say that we don't have any regulations around precluding that scenario from happening. I'm not sure about CDC because I know that they also have eligibility criteria that have to be met that are mostly near ours. There's a few minor differences in terms of who can enter the program. I would definitely encourage you to talk to someone at CDC about that.

If it's just someone attending the program with their family members but not getting counted, I guess, they might be okay with it, but I don't want to speak on their behalf. There's a lot of data and metrics that are gathered from CDC by each of these organizations for monitoring the program, the quality of the program on their end. You can just I think from our end, we're not regulating that. We wouldn't provide any payment for anyone that's not a beneficiary or someone who isn't eligible for the program.

Dolores Addison: Okay. Thank you.

Carly Bird: Mm-hmm (affirmative).

Phyllis: At this time, there are no further questions.

Carly Bird: Okay. This is Carly. I'll just thank everyone for joining the call today and encourage you to take a look at our website. It's go.cms.gov/mdpp or email if you do have a question mdpp@cms.hhs.gov. Kitty, I'm not sure if you wanted to say anything else before we end the call today.

Kitty Marx: Sure. No. Thank you, Carly. I wanted to thank you for participating and providing today's presentation, a lot of good information, and we appreciate all the questions from the participants. We appreciate your interest in the program and your suggestions to [inaudible 00:48:41]. As Carly indicated, we do take comments very seriously.

Any information, data, other suggestions that you can provide, we will continue to consider those as we improve the program over the next few years. I do want to thank you, Carly, and Chinara and Dr. Karol for participation on today's call. If there are questions that you have, Carly gave you the email address to ask questions directly on the MDPPI program.

The Tribal Affairs has its own mailbox at tribalaffairs@cms.hhs.gov. If you do have questions or suggestions for future all tribes or webinar topics, please send those. The recording for today's call will be posted on the American Indian Alaska Native website at [Edit 00:49:39 www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/All-Tribes-Calls.html]. This recording will be posted probably in the next few weeks, so ...

Phyllis:

Thank you everyone for today's participation and have a good rest of your day. Thank you.

[End]